certified by the provider's executive director or officer and an independent licensed public accountant or certified public accountant and shall meet all other requirements as noted in §(a)(3)(ii).

(ii) If the revised data referred to in §(a)(5)(i) is not received within 30 days of the provider's receipt of notification, the facility's rate may be reduced in accordance with §(a)(4)(iii) unless the Commissioner has granted an extension pursuant to §(a)(4)(i) or (ii).

(iii) In the event that the provider discovers that a report submitted to OMRDD is incomplete, inaccurate, or incorrect prior to receiving its new base period rate, the provider must notify OMRDD that such error exists. The provider will have 30 days from the date such notification is received by OMRDD to submit a revised report or additional data. Such data or report shall meet the certification requirements of the report being corrected. If the corrected data is received within a reasonable time before the issuance of the base period rate, OMRDD may incorporate the corrected data into its computation of the base period rate without the provider having to file an appeal application.

(iv) If the revised data referred to in §(a)(5)(iii) is not received within the time periods set forth in §(a)(5)(iii) above, the facility's rate may be reduced in accordance with §(a)(4)(iii).

(b) Requirements for Financial Records

(1) Each provider shall maintain facility specific financial records which reflect all expenditures made and revenues received for its operations.

(i) Such financial records shall include, but not be limited to salary and fringe benefit costs allocated to the following categories: direct care, clinical, program administration, agency administration, and support. Such financial records shall also include other than personal service program costs such as housekeeping and maintenance costs, cost of physical plant and amortization of lease-hold improvements, and related expenses.

(ii) The financial records shall include separate accounts for each type of expense and revenue included on the annual budget or annual cost report. Such sub-accounts and control accounts as are necessary for effective financial management may be established by the program.

(iii) All such financial records and any related records shall be subject to audit by the Commissioner, the Office of the State Comptroller, the State Department of Social Services and by agencies of the federal government as provided by law.

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(2) Financial report data and the related statistical information for non-State operated facilities shall be retained by the provider for a period of six years, and

(i) Be audited by a licensed or certified public accountant who is not on the staff of the provider, on the staff of any program operated by the provider, and who has no financial interest in the program operated by the provider and who is not an "affiliate," as such term is defined in §(c)(10)(ix)(d);

(ii) Include a statement of the findings and opinion of the licensed or certified public accountant.

(3) Financial report data and related statistical information for State operated facilities shall be retained for a period of six years.

(c) Rate Setting

(1) Client Days

(i) A client day shall be the unit of measure denoting lodging and services rendered to one client between the census taking hours of the facility on two successive days; the day of admission but not the day of discharge shall be counted. One client day shall be counted if the client is discharged on the same day the client is admitted providing that there was an expectation that the admission would have at least a 24-hour duration.

(ii) Reserve bed days as determined according to OMRDD's intermediate care facility requirements for reimbursement of reserved beds shall be considered as client days.

(2) Rate Cycle

(i) OMRDD shall employ a rate cycle comprising two rate periods for rate setting for intermediate care facilities.

(ii) This rate cycle shall be subdivided into two rate setting periods;

(a) A base period which shall encompass the first 12-month period of the two period rate cycle.

(1) For <u>non-State operated</u> facilities in Regions II and III[, the base period shall be from April 1, 1986 to March 31, 1987; and] <u>excluding those non-State operated facilities in Regions II and III designated or elected to a Region I reporting year-end and fiscal cycle in accordance with §(a)(1)(ii)(d)</u> beginning January 1, 1988 and for every rate cycle thereafter, the base period for non-State operated facilities shall be from January 1 to December 31.

(i) For non-State operated facilities in Region I designated or elected to a Region II or III reporting year-end and fiscal cycle in accordance with section §(a)(1)(ii)(d) the base period shall be from July 1, 1988 to December 31, 1988 and for every rate cycle thereafter the base period shall be from January 1 to December 31.

(3) For State operated facilities in all regions the base period shall be April 1, [1986] 1988 to March 31, [1987] 1989 and shall remain April 1 to March 31 for every rate cycle thereafter.

(b) A subsequent period which shall encompass the second 12-month period of the two period rate cycle, except as noted in subsections (1) and (2) below:

(1) For non-State operated facilities in Region II and III[, the subsequent period shall be from April 1, 1987 to December 31, 1987; and] excluding those facilities in Regions II and III designated or elected to a Region I reporting year-end and fiscal cycle in accordance with (a)(1)(ii)(d) beginning January 1, 1989 and for every rate cycle thereafter, the subsequent period shall be from January 1 to December 31.

(2) For non-State operated facilities in Region I, including these facilities in Region II and III designated or elected to a Region I reporting year-end and fiscal cycle in accordance with §(a)(1)(ii)(d) the subsequent period shall be from April 1, 1987 to June 30, 1988; and beginning July 1, 1989 and for every rate cycle thereafter, the subsequent period shall be from July 1 to June 30.

(i) For non-State operated facilities in Region I designated or elected to a Region II or III reporting year-end and fiscal cycle in accordance with section (a)(1)(ii)(d) the subsequent period shall be from January 1, 1988 to June 30, 1988. Beginning January 1, 1989 and for every rate cycle thereafter the subsequent period shall be from January 1 to December 31.

(3) For State operated facilities in all regions, the subsequent period shall be from April 1, [1987] 1989 to March 31, [1988] 1990 and for every rate cycle thereafter, the subsequent period shall be from April 1 to March 31.

(3) Computation of the base period rate

(i) Establishment of Rates

(a) For each facility the commissioner shall establish rates of reimbursement which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. Such rates shall be set in accordance with certified capacity as stated in a facility's provider agreement, except as noted in Section (c)(3)(iii) and Section (c)(3)(vii), and except for developmental centers.

(b) Payment rates for the base period shall be computed on the basis of a full 12 month cost report submitted by the provider for the 12 month period beginning 24 months prior to the effective date of the base period, and subject to the category standards described herein. If cost report data are not utilized, then the most recently available budget data shall be used as stated in Section (a)(1)(i).

(c) (1) Notwithstanding any other provisions of this State Plan, the reimbursable operating costs contained in the payment rates for the period from January 1 through December 31 shall be equal to the reimbursable operating costs and appropriate appeal adjustments included in the payment rates in effect on December 31 of the immediately preceding rate cycle applicable to that facility, increased by the trend factor identified in (c)(3)(vi). This shall apply to all facilities which have initial certification dates on or before December 31 of the immediately preceding rate cycle, and which are:

(a) located in Region II or III and which have neither been designated to nor have elected a Region I cycle in accordance with (a)(1)(ii)(d); or [and]

(b) located in Region I and which have been designated to or have elected a Region II and III cycle in accordance with (a)(1)(ii)(d).

(2) Notwithstanding any other provisions of this State Plan, the reimbursable operating costs contained in the payment rates for the period July 1 through June 30 shall be calculated as follows. The reimbursable operating costs and appropriate appeal adjustments included in the payment rates in effect on June 30 of the immediately preceding rate cycle applicable to that facility, shall be increased by the trend factor described in (c)(3)(vi). This shall apply to all facilities which have initial certification dates on or before June 30 of the immediately preceding rate cycle and which are:

(a) located in Region I and which have neither been designated to nor have elected a Region II or III cycle in accordance with (a)(1)(ii)(d); or [and]

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(b) located in Region II or III and which have been designated to or have elected a Region I cycle in accordance with (a)(1)(ii)(d).

(3) Notwithstanding any other provisions of this State Plan, the April 1 to March 31 payment rate for State operated community facilities shall be calculated by trending the reimbursable operating costs and appropriate appeal adjustments contained in the rate in effect on March 31 of the immediately preceding rate cycle applicable to that facility, appropriately adjusted for those costs resulting from Developmental Center Closure Incentive Plans (DCCIP) approved in accordance with subsection (c)(7)(e) and (f). Such costs shall be increased by the trend factor described in subdivision (c)(3)(vi). This method of calculation is applicable to all State operated community facilities with initial certification dates on or before March 31 of the immediately preceding rate cycle.

(4) Start-up and capital costs of rates determined in accordance with subparagraphs (1),(2) and (3) above will be calculated pursuant to the provisions of this State Plan identified in section (c)(5) and (c)(10) respectively. Such costs will not be trended.

(5) For all other facilities not covered by subparagraphs 1, 2 and 3, payment rates shall be calculated in accordance with this State Plan, utilizing budget data, subject to the cost category standards and case mix methodology identified herein and using the calendar year, or July 1 to June 30 or April 1 to March 31 rate year applicable pursuant to (c)(2).

(6) Notwithstanding any other provisions of this State Plan, for developmental centers, the Statewide average rate for the period from April 1 to March 31 shall be calculated as follows. The reimbursable operating costs contained in the payment rate in effect on March 31 of the immediately preceding rate cycle, after adjustment for the latest, available projected number of client days, shall be increased by the trend factor described in subdivision (c)(3)(vi). In addition, if substantial, material changes that conform to the requirements of section (d)(1)(iv) are projected for the rate year these changes may be incorporated into the computation of the April 1 to March 31 period rate without an appeal being filed. OMRDD shall perform a rate year end volume variance adjustment to the April 1 to March 31 period rate for developmental centers by taking into account recalculated operating costs based upon a fixed to variable ratio of 64 percent fixed/36 percent variable, and actual client days. The rate which results from the above calculation is subject to the provisions of (c)(8)(vi) and (vii).

(a) For a newly certified facility, the base period rate shall be determined by dividing the total reimbursable operating costs by 99 percent of the total client days as determined by multiplying the certified capacity of the facility by 365 days. As used in the preceding sentence, "total reimbursable operating costs" shall mean the lower of a facility's submitted budget costs or the cost category standards. A facility's submitted budget costs may be adjusted based on a comparison to the actual costs of other existing programs operated by the provider in order to determine a reasonable and economic level of reimbursable operating costs. If the provider does not operate other programs, the submitted budget costs may be adjusted based on a comparison to the actual costs of similar facilities in the same region. A "newly certified facility" shall mean a facility which has been in operation less than two full years as of the date of the start of the "rate cycle" as defined in §(c)(2)(ii).

(b) For facilities other than "newly certified facilities" as defined above, the base period rate shall be determined by dividing the total reimbursable operating costs by the higher of either the actual reported client days or 99 percent of the total client days as determined by multiplying the certified capacity of the facility by 365 days. As used in the preceding sentence "total reimbursable operating costs" shall mean the lower of a facility's submitted cost report costs, or the cost category standards. If the submitted cost report costs have undergone substantial material changes, and if said changes conform to the requirements of §(d)(1)(iv) and have received prior approval by OMRDD and Division of Budget, these changes may be incorporated into the computations of the base period rate without the facility being required to file an appeal.

(iii) The Commissioner may make adjustments to a provider's cost report expenditures based on allowability of costs as determined by §(c) and HIM-15, where applicable, or adjustments to rates based upon errors which occurred in the computation of the rate, changes in payments for real property which have the prior approval of the commissioner and the director of the Division of the Budget, changes in capacity or based upon previously determined final audit findings made in accordance with §(e). If a facility has undergone a change in certified capacity the Commissioner may at his discretion:

(a) Request the facility to submit a budget report subject to the provisions of §(a)(1)(i)(b) or,

(b) Request the facility to submit incremental/decremental cost data, if available, which is associated with the capacity change; and

(c) Utilize submitted incremental/decremental data to make the appropriate upward or downward adjustment in a facility's rate; or

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(d) Continue the then existing rate for the remainder of the subject rate period, in those instances where the commissioner has determined that the facility is operating at a loss for the rate period in question, and adjusting the rate would further increase the loss, or the facility is operating at a surplus for the rate period in question and adjusting the rate would further increase the surplus.

(iv) Rate adjustments as described in section (c)(3) (iii) shall be limited to those adjustments which will result in an annual increase or decrease in reimbursement of $500 or more.

(v) When regional comparisons are involved in determining the reimbursable costs, the geographic regions which OMRDD will consider are: New York City (Region I); New York City Suburban (Region II), and Upstate New York (Region III). Regional comparisons may include but not be limited to cost data from intermediate care facilities operated by both State and voluntary agencies.

(a) New York City includes the counties of New York, Bronx, Queens and Kings and Richmond.

(b) New York City Suburban includes the counties of Putnam, Rockland, Nassau, Suffolk and Westchester.

(c) Upstate New York includes all counties not included in the previous two categories.

(vi) As appropriate, OMRDD shall apply trend factors to each facility's total reimbursable operating costs as determined by section (c) and as submitted on the budget or cost reports required by section (a)(1)(i) and (ii) respectively. Except for educational and related services as defined at (3)(vii)(b)(3), s[S]uch trend factors shall be applied to only reimbursable operating costs, with capital costs and start-up costs added to this result to compute the final base period rate.

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(a) For all facilities, effective on the first day of the applicable fiscal cycle the trend factor utilized shall be that figure developed by the New York State Department of Health, incorporating the estimated current price

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movement for the applicable fiscal year for voluntary operated residential health care facilities. The following components of the statewide price movement for voluntary operated residential health care facilities are considered:

(1) Wages
(2) FICA
(3) Fringe Benefits
(4) OTPS

(b) Each weighted element percentage shall be multiplied by the appropriate price index for each category noted above. (The term "weighted" shall mean the percentage derived by dividing each of the aforementioned elements of hospital and nursing home operating costs by the total operating cost.) For wages, the price index utilized is the United States Department of Labor Employment Cost Index (ECI-US). For fringe benefits, the price index utilized is the ratio of the ECI-US with fringe benefits to ECI-US without fringe benefits. For OTPS, the price index utilized is the implicit Gross National Product Deflator. The sum of the products of all the weighted elements multiplied by their appropriate price index shall equal the trend factor.

(c) A review of cost trends within the ICF/DD industry will be undertaken prior to the beginning of a rate period. Should such a review show that the previous trend factor did not accurately reflect the cost trends in the ICF/DD industry a substitution or supplementation may be made. Should the review show that the previous trend factor was sufficient to accurately reflect the actual rate of inflation in the period under review no substitution or supplementation will be made. For the rate periods beginning January 1, 1990, April 1, 1990 and July 1, 1990, two percent will be added to the 1990 component of the trend factor.

For the rate periods beginning January 1, 1997, April 1, 1997 and July 1, 1997, 2.53 percent will be added to the 1997 component of the trend factor.

(vii) For facilities under 31 beds there shall be day program base period rate adjustments such that facilities which have day services included in their operating costs shall be reimbursed in their base period rate for these services. Day program refers to a certified facility(ies) wherein services are provided. Day services shall be defined as those services which are a part of an active treatment plan as defined at 42 CFR 483.440(a), and are delivered on an outpatient basis at a certified day program location. Day services may include day treatment, sheltered workshop, day training, and education and education related services.

(a) Day treatment - A facility shall be reimbursed up to a maximum of 225 days per year for day treatment services, i.e., a planned combination of diagnostic, treatment and habilitation services. The facility will be reimbursed at the lower of the actual operating costs per the cost report or the per diem fee for any day treatment services as calculated below. Capital costs and utility costs are already included in the residential component of the rate. The per diem fee for day treatment services shall be a fixed amount plus the component add-ons for case mix, staff training, region and salary enhancement. In addition to the aforementioned, the fee for programs that are located in Region II but have administrative offices located principally in Region I, will include a component add-on for regional administration.

(1) The fixed amount shall be $41.34.

(2) The component add-ons shall be computed as follows: (Rounded up to the nearest cent for 0.5 cents or larger.)

(i) Case Mix Component - There shall be no case mix component for programs with an average Developmental Disabilities Information Survey (DDIS) score per client of 10 points or less.